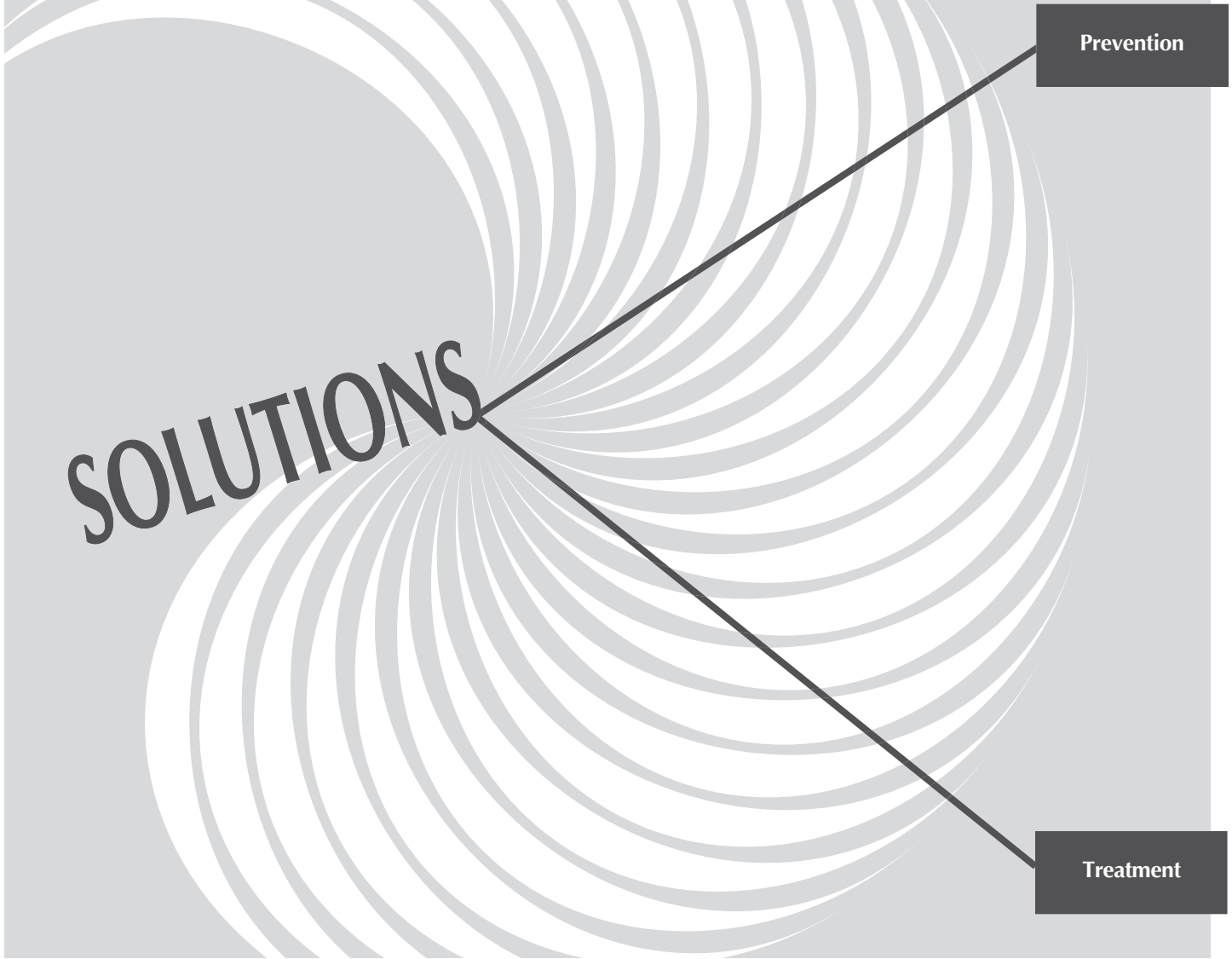
Solutions: Substance Abuse Prevention & Treatment



Introduction

State Law RCW 70.96A identifies the Division of Alcohol and Substance Abuse (DASA) as the "single state" agency for planning and delivery of substance abuse treatment and prevention services. All public substance abuse services funded by state or federal funds are either managed by DASA or operate in coordination with DASA (for example, services provided by the Department of Health, the Department of Licensing, the Department of Corrections, and the Office of the Superintendent of Public Instruction).

DASA does not provide direct prevention or treatment services, but rather, provides these services through contracts with county governments, Indian tribes, and non-profit service providers. The largest portion of available federal and state funds are contracted through county and tribal governments. Each biennium, DASA develops a plan for program development and prevention and treatment service strategies.

County governments and tribes are awarded prevention and treatment funds on the basis of a formula established by DASA in coordination with these governmental units. Counties and tribes are expected to conduct a needs assessment for prevention and treatment needs, based on available funding, and submit a plan to DASA. Contracts for community-based prevention and treatment services are written to include work statements specifying the activities which will be provided under the contracts.

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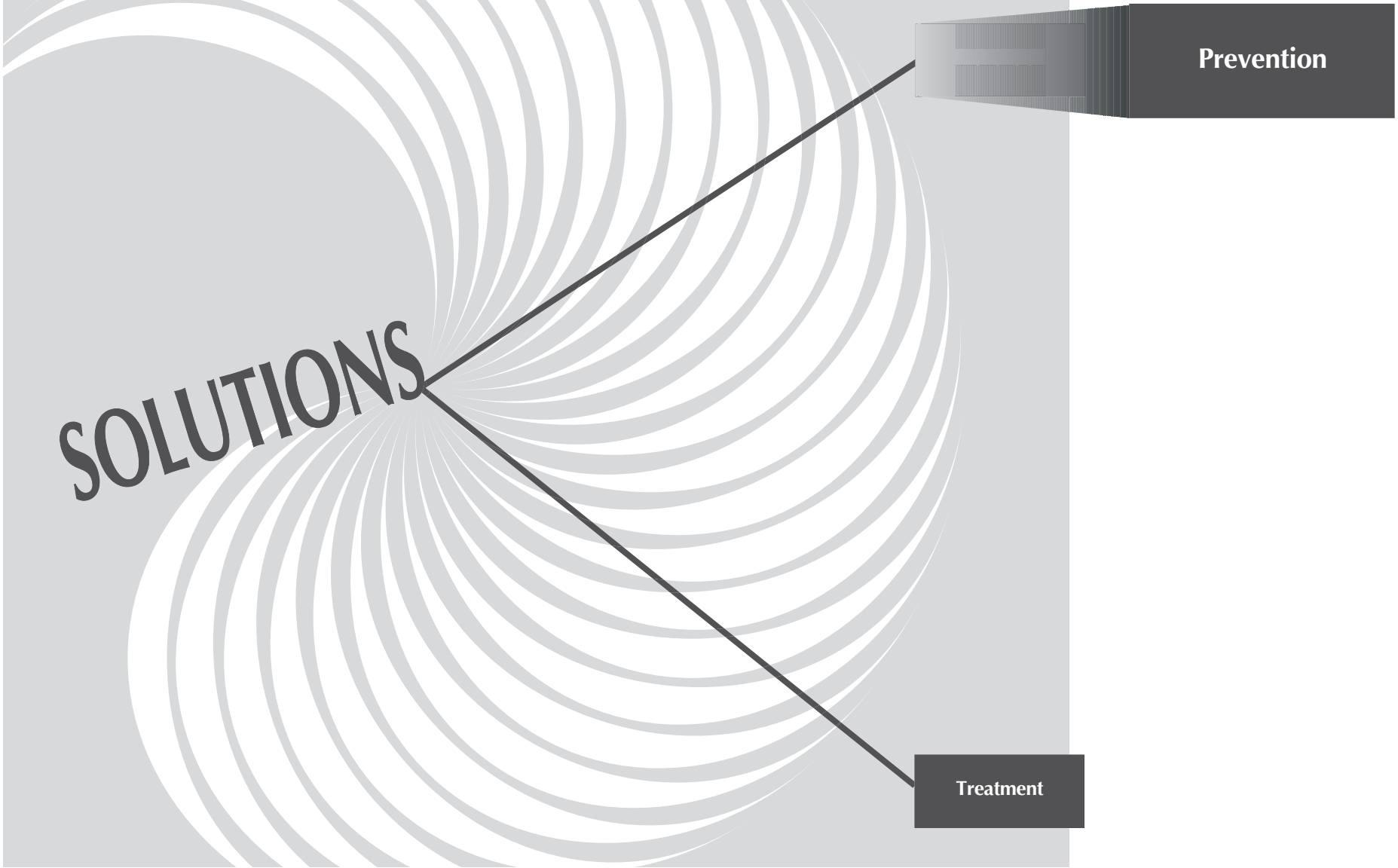


Prevention

Washington's youth are faced with choices every day that may result in a variety of problem behaviors. Among the most dangerous of those behaviors is the abuse of alcohol, tobacco, and other drugs. It is the Division of Alcohol and Substance Abuse's (DASA) policy that any use of illicit drugs and the inappropriate use of legal drugs, including alcohol, are considered drug abuse. DASA's goal for the majority of prevention programs it supports is two-fold: programs should act to *delay* the onset of alcohol and tobacco use, and also act to *prevent* the abuse of alcohol, tobacco, and other drugs.

DASA contracts with counties and tribes to provide services at the community level. The Risk and Protective Factor Framework is the cornerstone of all program investments.

Risk and Protective Factor Framework

Over the past two decades, much research has focused on determining how drug abuse begins and how it progresses. Just as medical researchers have found risk factors for heart disease (e.g., lack of exercise, smoking), prevention research has identified a set of risk factors and protective factors related to drug abuse. The more risk factors a child is exposed to, the more likely the child will abuse drugs, alcohol, or tobacco. Some risk factors may be more powerful than others at certain stages in development, such as peer pressure during the teenage years. At each stage, risks occur that can be changed through prevention intervention. Early childhood risks, such as aggressive behavior, can be changed or prevented with family, school, and community interventions that focus on helping children develop appropriate, positive behaviors. If not addressed, negative behaviors can lead to more risks, such as academic failure and social difficulties, which, in turn, put children at further risk for drug abuse later in life.

Not every young person who is exposed to multiple risks becomes a substance abuser, juvenile delinquent, school dropout, or teen parent. There are conditions – known as protective factors – that can counter the risks. Protective factors are buffers in the lives of young people that either reduce the impact of the risk or change the way a person responds to the risk. A strong parent-child bond is an example of a primary protective factor. When children are strongly attached to positive families, friends, schools, and communities, they are more likely to be committed to achieving the goals valued by these groups and are less likely to develop problems as a teenager.

Risk and protective factor-focused prevention programs are based on a simple premise: to prevent a substance abuse problem, we must identify those factors that increase the likelihood of that problem developing and then intervene in ways that reduce the risk. At the same time, we must identify protective factors that buffer individuals from the risks present in their environments and then find ways to strengthen the protection.[1]

Many risk factors associated with adolescent substance abuse are also tied to other problem behaviors, including: delinquency, teen pregnancy, school dropout, violence, and depression/anxiety. While the primary focus of prevention programs supported by DASA is substance abuse, addressing its risk factors will likely impact multiple problem behaviors.

Risk and protective factors fall into four domains. Research indicates that by reducing risk factors and enhancing protective factors in each of the domains, the likelihood that youth will engage or experience problem behaviors can be substantially reduced.

The four domains are:

- Community
- Family
- School
- Individual/Peer

[1] Hawkins, J., Catalano, R. & Miller, J. "Risk and Protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention." *Psychological Bulletin.* 112 (1),1992

Risk Factors and Adolescent Problem Behavior

RISK FACTORS BY DOMAIN ▼	Substance Abuse	Delinquency	Teen Pregnancy	School Dropout	Violence	Depression/ Anxiety
Community						
Availability of Drugs	■				■	
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	■	■			■	
Transitions and Mobility	■	■		■		■
Low Neighborhood Attachment and Community Disorganization	■	■			■	
Extreme Economic Deprivation	■	■	■	■	■	
Family						
Family History of the Problem Behavior	■	■	■	■	■	■
Family Management Problems	■	■	■	■	■	■
Family Conflict	■	■	■	■	■	■
Favorable Parental Attitudes and Involvement in the Problem Behavior	■	■			■	
School						
Academic Failure Beginning in Late Elementary School	■	■	■	■	■	■
Lack of Commitment to School	■	■	■	■	■	
Individual/Peer						
Early and Persistent Antisocial Behavior	■	■	■	■	■	■
Rebelliousness	■	■		■		
Friends Who Engage in the Problem Behavior	■	■	■	■	■	
Favorable Attitudes Toward the Problem Behavior	■	■	■	■		
Early Initiation of the Problem Behavior	■	■	■	■	■	
Constitutional Factors	■	■			■	■
Gang Involvement	■	■			■	

Source: Social Development Research Group, University of Washington.

Prevention Works!

In 2003, the Washington State Legislature requested the Washington State Institute for Public Policy examine prevention and early intervention programs for youth. The purpose was to see whether there is credible scientific evidence to indicate that research-based prevention programs can produce benefits for communities that outweigh financial costs. Some 60 programs were evaluated. Their conclusion, published in a report to the Legislature in July 2004, was that certain well-chosen and well-implemented programs, including programs being used in Washington State, can achieve such benefits.[1] Several such programs are profiled on the following pages.

Principles of Effective Substance Abuse Prevention

In Washington State, the Division of Alcohol and Substance Abuse contracts with county prevention providers. Providers are required to use scientifically based best practices for at least 50% of programming. When choosing to design and implement other programs, providers are required to refer to the federal Center for Substance Abuse Prevention's *Principles of Substance Abuse Prevention* and apply the 78 scientifically defensible principles – which are divided by domain – to their work in communities.[2]

The following pages provide examples of programs being implemented in Washington State that have been scientifically demonstrated to work.

Individual Domain

- Build social and personal skills.
- Design culturally sensitive interventions.
- Cite immediate consequences.
- Combine information dissemination and media campaigns with other interventions.
- Provide positive alternatives to help youth in high-risk environments develop personal and social skills in a natural and effective way.
- Recognize that relationships exist between substance use and a variety of other adolescent health problems.
- Incorporate problem identification and referral into prevention programming.
- Provide transportation to prevention programs.

[1] Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA: Washington State Institute for Public Policy, 2004.
[2] Center for Substance Abuse Prevention. *Principles of Substance Abuse Prevention*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Division of Knowledge Development and Education, 2001. Detailed descriptions of each principle can be found at: www.samhsa.gov/centers/csap/modelprograms/pdfs/pubs_Principles.pdf.

Family Domain

- Target the entire family.
- Help develop bonds among parents in programs; provide meals, transportation, and small gifts; sponsor family outings; and ensure cultural sensitivity.
- Help minority families respond to cultural and racial issues.
- Develop parenting skills.
- Emphasize family bonding.
- Offer sessions where parents and youth learn and practice skills.
- Train parents to both listen and interact.
- Train parents to use positive and consistent discipline techniques.
- Promote new skills in family communication through interactive techniques.
- Employ strategies to overcome parental resistance to family-based programs.
- Improve parenting skills and child behavior with intensive support.
- Improve family functioning through family therapy when indicated.
- Explore alternative community sponsors and sites for schools.
- Videotape training and education.

Peer Domain

- Structure alternative activities and supervise alternative events.
- Incorporate social and personal skill-building opportunities.
- Design intensive alternative programs that include a variety of approaches and substantial time commitment.
- Communicate peer norms against use of alcohol and illicit drugs.
- Involve youth in the development of alternative programs.
- Involve youth in peer-led interventions, or interventions with peer-led components.
- Counter the effects of deviant norms and behaviors by creating an environment for youth with behavior problems to interact with other nonproblematic youth.

School Domain

- Avoid relying solely on knowledge-oriented interventions designed to supply information about negative consequences.
- Correct misconceptions about the prevalence of use in conjunction with other education approaches.
- Involve youth in peer-led interventions or interventions with peer-led components.
- Give students opportunities to practice newly acquired skills through interactive approaches.
- Help youth retain skills through booster sessions.
- Involve parents in school-based approaches.
- Communicate a commitment to substance abuse prevention in school policies.

Community Domain

- Develop integrated, comprehensive prevention strategies rather than one-time community-based events.
- Control the environment around schools and other areas where youth gather.
- Provide structured time with adults through mentoring.
- Increase positive attitudes through community service.
- Achieve greater results with highly involved mentors.
- Emphasize the costs to employers of workers' substance use and abuse.
- Communicate a clear company policy on substance abuse.
- Include representatives from every organization that plays a role in fulfilling coalition objectives.
- Retain active coalition members by providing meaningful rewards.
- Define specific goals and assign specific responsibility for their achievement to subcommittees and task forces.
- Ensure planning and clear understanding for coalition effectiveness.
- Set outcome-based objectives.
- Support a large number of prevention activities.
- Organize at the neighborhood level.
- Assess progress from an outcome-based perspective and make adjustments to the plan of action to meet goals.
- Involve paid coalition staff as resource providers and facilitators rather than as direct community organizers.

Society/Environmental Domain

- Develop community awareness and media efforts.
- Use mass media appropriately.
- Provide structured time with adults through mentoring.
- Avoid the use of authority figures.
- Broadcast messages frequently over an extended period of time.
- Broadcast messages through multiple channels when the target audience is likely to be viewing or listening.
- Disseminate information about the hazards of a product or industry that promotes it.
- Promote replacement of more conspicuous labels.
- Promote restrictions on tobacco use in public places and private workplaces.
- Promote clean indoor air laws.
- Combine beverage server training with law enforcement.
- Combine beverage servers' legal liability with laws against service to intoxicated patrons and against sales to minors.
- Increase the price of alcohol and tobacco through excise taxes.
- Increase minimum purchase age for alcohol to 21.
- Limit the location and density of retail alcohol outlets.
- Employ neighborhood anti-drug strategies.
- Enforce minimum purchase age laws using undercover buying operations.
- Use community groups to provide positive and negative feedback to merchants.
- Employ more frequent enforcement operations.
- Implement "use and lose" laws.
- Enact deterrence laws and policies for impaired driving.
- Enforce impaired-driving laws.
- Combine sobriety checkpoints with positive passive breath sensors.
- Revoke licenses for impaired driving.
- Immobilize or impound vehicles of those convicted of impaired driving.
- Target underage drivers.

Prevention Works!

Prevention programs address risk and protective factors in four domains. Research indicates that by reducing risk factors and enhancing protective factors in each of the domains, the likelihood that youth will engage or experience problem behaviors can be substantially reduced. Below are descriptions of programming in each domain, and a description of programs being utilized in each domain among Washington's counties and tribes.

Community Domain Programming

In community domain programming, anti-drug norms and pro-social behaviors are strengthened through the involvement of civic, religious, law enforcement, and other government organizations. Many programs coordinate prevention efforts to communicate consistent messages through school, work, religious institutions, and the media. Research has shown that programs that reach youth through multiple settings can strongly impact community norms. Community-based programs may also include policy development, law enforcement, mass media efforts, and community-wide awareness efforts. Some carefully structured and targeted media interventions have proven to be very effective in reducing drug abuse.

To determine the level of risk/protective factors in the community domain, both archival and data from the Adolescent Health Behavior Survey are utilized. Archival indicators include: number of alcohol sales outlets and tobacco distributors; number of children in families receiving some form of public assistance; population not voting in elections; and net migration. Survey indicators include: perceived availability of drugs; laws and norms favorable to drug use; personal transitions and mobility; and opportunities and rewards for pro-social involvement.

The following community evidence-based programs and strategies were implemented in Washington counties and tribes in the 2003-2005 Biennium:

Communities that Care® (CTC) provides research-based tools to guide communities through a process leading to a place to promote the positive development of children and youth, and prevent adolescent problem behaviors that impede positive development. Implemented in Cowlitz and Snohomish Counties.

Community Trials Intervention to Reduce High-Risk Drinking is a multi-component program developed to alter alcohol use patterns of people of all ages, to combat drinking and driving, underage drinking, binge drinking, and related problems. Implemented in Kittitas County.

Counter-Advertising uses the media to promote negative images about tobacco use, reveal the number of teens who actually use tobacco, and emphasize the unacceptability of tobacco use. It counters tobacco industry advertising that links tobacco use with peer acceptance, success, and good times. Implemented in Whitman County.

Project Northland consists of social-behavioral curricula in schools, peer leadership training among youth to increase peer pressure resistance and social competence skills, parental involvement/education to provide parental support and modeling, and community-wide taskforce activities aimed at changing the larger environment. Implemented in Mason County.

Retail-Directed Interventions include merchant and community education about adolescent tobacco use and laws prohibiting tobacco sales to minors, and enactment and enforcement of laws prohibiting tobacco sales to minors. Implemented in Grays Harbor and Kitsap Counties.

Tobacco-Free Environmental Policies are directed at creating environments where youth are not exposed to the possession and use of tobacco. Activities include: reviewing existing laws and compliance with laws restricting tobacco use; reviewing the effects of anti-smoking school policies on adolescent smoking; providing technical assistance and guidance on developing and implementing tobacco-free policies and environments.

Family Domain Programming

Risk factors are reduced among young children by teaching parents better family management practices, such as communication skills, appropriate discipline styles, and firm and consistent rule enforcement. Research confirms the benefits of parents providing consistent rules and discipline, talking to children about drugs, monitoring their activities, getting to know their friends, understanding their problems and concerns, and being involved in their learning. The importance of the parent-child relationship continues through adolescence.

Archival indicators are used to determine the level of risk/protective factors in the family domain. These include: divorce rates; domestic violence arrests; percentage of adults in chemical dependency treatment programs; alcohol- and drug-related deaths; percentage of children living in foster care or away from home; number of victims in accepted referrals to Child Protective Services.

The following community evidence-based programs and strategies were implemented in Washington counties and tribes in the 2003-2005 Biennium:

Creating Lasting Family Connections assists high-risk youth ages 11-15 and their families to become strong, healthy, and mutually supportive. The program provides parents and youth with defenses against environmental risk factors by teaching appropriate skills for personal growth, family enhancement, and interpersonal communication, including refusal skills for both parents and youth. Implemented in King County.

Families in Action is a program aimed at families in rural school districts with students entering middle or junior high school. Implemented in Skamania County.

Guiding Good Choices® (formerly known as Preparing for the Drug-Free Years) is a multi-media program that provides parents of children in 4th through 8th grades the knowledge and skills necessary to guide their children through early adolescence. The program aims to strength and clarify family expectations for behavior, enhance the conditions that promote bonding in the family, and teach skills to parents and children to successfully meet the expectations of their family and resist alcohol, drug, and tobacco use. Implemented in Benton/Franklin, King, and Yakima Counties.

Home Visiting provides a bridge between a parent with a young child and the outside world by way of a visitor who cares about the raising of children. The visitor may provide information and/or emotional support. Visitors may be trained in health (e.g. nurses), human development (psychologists or social workers), cognitive and social skills instruction (preschool teachers), or some combination (paraprofessionals). Implemented in Clallam County.

Incredible Years helps parents improve communication skills with their children, enhance limit-setting skills by means of nonviolent discipline techniques, develop their own problem-solving skills, and learn effective methods of anger management. Implemented in Clallam and Yakima Counties.

NICASA Parenting Project is implemented in the workplace and enriches family relationships and promotes healthy environments that build resistance to social and personal dysfunction. It focuses on the need to establish supportive networks among working parents, improve parent/child relationships, increase ability to balance work and family life, enhance the corporate climate for workers, and improve parenting skills. Implemented in Clark County.

Nurturing Programs are family-centered and build nurturing skills as alternatives to abusive childrearing attitudes and practices. Implemented in Ferry, King, Lewis, Spokane, and Whitman Counties.

Parenting Skills Programs teach communication and child management skills in order to improve parent-child relationships and foster good psychosocial adjustment in children. Implemented in King County.

Parenting Wisely is an interactive CD-ROM-based program designed for at-risk families with children from early elementary to high school age. This format overcomes illiteracy barriers, thereby meeting the needs of families who do not usually attend or finish parenting education. It seeks to help families enhance relationships and decrease conflict through behavior management and support, and builds confidence in parenting skills. This program has been presented in Spanish, as well as English. Implemented in Thurston County.

Parent and Family Skills Programs enable families to better nurture and protect their children, help children develop pro-social behaviors, and train families to deal with particularly challenging children. Implemented in Kitsap County.

Parents as Teachers is an early childhood parent education and support program serving families from pregnancy through kindergarten. The program provides: 1) personal visits – certified parent educators help parents understand and have appropriate expectations for each stage of their child's development; 2) group meetings – parents meet to enhance their parenting knowledge, gain new insights and share their experiences, common concerns, and successes; 3) developmental screenings – periodic screening of overall development, health, hearing, and vision to provide early detection of potential problems and prevent later difficulties in school; and 4) linkage to a resource network – families are assisted in accessing other needed community services. Implemented in Garfield County.

Parents Who Care is a skill-building program created for families with children between ages 12-16. It is grounded in the social development model, emphasizing that young people should experience opportunities for active involvement in family, school, and community, develop skills for success, and be given recognition and reinforcement for positive effort and improvement. It focuses on strengthening family bonds and establishing clear standards for behavior, helping parents more appropriately manage their teenager's behavior while encouraging their adolescent growth toward independence. Implemented in Clallam and Okanogan Counties.

Storytelling for Empowerment is based on the understanding that storytelling has been used for centuries by humans to pass on values and cultural identity, and as such is a natural vehicle for nurturing resiliency factors in youth. This approach enhances the buffering effects of a positive peer group and a positive cultural identity. It is designed for club and classroom settings serving American Indian and Latino-Latina middle school youth. The program addresses the confusion of cultural identity, the lack of congruence of multicultural learning styles and instruction, and the lack of consistent, positive parental role models. Implemented in King County.

Strengthening Families Program involves elementary school children ages 6-12 and their families in family skills training sessions. It uses family systems and cognitive/behavioral approaches to increase resiliency and reduce risk factors for behavioral, emotional, academic, and social problems. It builds on protective factors by improving family relationships, enhancing parenting skills, and increasing the youth's social and life skills. Implemented in Cowlitz, Garfield, Grant, Grays Harbor, Mason, Pend Oreille, Skagit, Thurston, and Wahkiakum Counties.

Strengthening Families Program: For Parents and Youth 10-14 resulted from an adaptation of the Strengthening Families Program (SFP). It focuses on improving parental skills in nurturing and child management, and enhancing interpersonal and personal competencies and pro-social skills among youth. Videotapes portraying pro-social behaviors are utilized and are appropriate for multi-ethnic families. This program has been presented in English and Spanish. Implemented in Adams, Asotin, Benton/Franklin, Chelan/Douglas, Columbia, Ferry, Island, King, Lewis, Lincoln, Okanogan, San Juan, Skagit, Spokane, Stevens, Wahkiakum, Whatcom, and Yakima Counties, and the Spokane Tribe.

Strengthening Multi-Ethnic Families and Communities targets ethnic minority parents of children ages 3-18 who are interested in raising children with a commitment to leading a violence-free, healthy lifestyle. Short-term objectives are to increase parents' sense of competence, positive family/parent/child interactions and relationships, child self-esteem and self-discipline, child social competency skills, and increased parental involvement in churches, schools, community agencies, and other locations. Implemented in King, Pierce, and Snohomish Counties.

School Domain Programming

School domain programming focuses on the social and academic skills of children, including peer relationships, self-control, coping, and drug-refusal skills. School-based prevention programs are most successful when integrated into the academic program, because school failure is strongly associated with drug abuse. Integrated programs strengthen the student-school bond and reduce the likelihood of dropping out. Other types of interventions include school-wide programs that affect the school environment as a whole. All of these activities can serve to strengthen protective factors against drug abuse.

Both archival and Adolescent Health Behavior Survey data are used to determine the risk/protective factors in this domain. Archival data include: high school dropout rates; academic failure; and poor academic performance in grades 4 and 8. Survey data include: commitment to school; and opportunities for pro-social involvement.

The following community evidence-based programs and strategies were implemented in Washington counties and tribes in the 2003-2005 Biennium:

Tutoring Programs improve academic success among elementary school children who have serious academic problems in reading and/or mathematics. Initial tutoring sessions involve an assessment of the child's successes and failures in regular classroom reading material. Tutors are trained in the use of behavior techniques to help children attempt tasks they would otherwise avoid. Implemented in Kitsap and Pierce Counties.

Across Ages is a school- and community-based program for youth ages 9-13 that seeks to strengthen the bonds between adults and youth, and provide opportunities for positive community involvement. A unique feature of Across Ages is the pairing of older adult mentors (age 55 and above) with young adolescents, specifically youth making the transition to middle school. The program employs mentoring, community service, social competence training, and family activities to build youths' sense of personal responsibility for self and community. Implemented in Benton/Franklin Counties.

PAL® Peer Assistance and Leadership Programs are driven by needs assessment and include the following: group and one-to-one peer tutoring and mentoring; activities and group discussions on issues such as alcohol and substance use, and career choices; peer mediation and conflict resolution services; and participation in community service projects. The programs seek to develop communication, decision-making, problem-solving, team and relationship-building, and refusal skills. Implemented in Pend Oreille and Walla Walla Counties.

Individual/Peer Domain Programming

In individual/peer domain programming is primarily directed at enhancing protective factors. Positive bonding is one of the protective factors that can buffer a young person who is exposed to multiple risk factors. Bonding is most likely to occur when youth are given opportunities to contribute in a meaningful way to their community, family, peers, and/or school; are taught the skills necessary to be successful in that opportunity; and are recognized for their efforts. Individuals are also provided information about the negative consequences of risky behaviors, including substance abuse.

Both archival and Adolescent Health Behavior Survey data are utilized in determining the level of risk in the individual/peer domain. Archival data include: alcohol- and drug-related arrests, ages 10-14; property crime arrests, ages 10-14; and vandalism arrests, ages 10-14. Survey data include: rebelliousness; antisocial behavior; friends' use of drugs; interaction with antisocial peers; favorable attitudes toward drug use and/or antisocial behavior; perceived risks of drug use; perceived rewards for antisocial behavior; and early initiation of problem behaviors.

The following community evidence-based programs and strategies were implemented in Washington counties and tribes in the 2003-2005 Biennium:

All Stars comes in two formats: middle school classroom- and community-based formats. Each reinforces the belief that risky behaviors are not normal or acceptable by the adolescent's peer group; cultivates the belief that risky behaviors do not fit with the youth's personal ideals and future aspirations; creates strong, voluntary personal and public commitments to not participate in risky behaviors; strengthens relationships between adolescents, social institutions, and significant adults; and helps parents listen to their children, communicate clear no-use expectations about alcohol and other drugs, and support their children in working toward positive life goals. Implemented in Ferry, Grant, King, and Pacific Counties.

Big Brothers/Big Sisters is a mentoring program that matches an adult volunteer with a child, with the expectation that a caring and supportive relationship will develop. A professional staff member selects, matches, monitors, and closes the relationship with the volunteer and child, and communicates with the volunteer, parent/guardian, and the child throughout the matched relationship. Implemented in Clark, Ferry, Island, Jefferson, King, Pierce, San Juan, Skamania, Snohomish, Spokane, and Whatcom Counties, and the Jamestown S'Klallam Tribe.

Brys Behavioral Monitoring and Reinforcement Program is a school-based, early intervention program based on behavior modification and teaching thinking skills. The program targets 7th and 8th graders and includes the following components: recording daily attendance and discipline referrals of program participants, weekly discussions with students in small groups about what to do to improve their teacher's impression of their behavior, and rewarded for every day that they come to school, arrive on time, and receive no disciplinary action. Implemented in Island and Spokane Counties.

Friendly PEERsuasion® is directed at girls of middle school age, ages 11-14, to help them acquire the knowledge, skills, and support systems to avoid substance abuse. Implemented in Walla Walla County.

LifeSkills®Training is a three-year prevention curriculum intended for middle school or junior high school students. It covers three major content areas: drug resistance skills and information, self-management skills, and general social skills.

Implemented in Chelan/Douglas, Ferry, Grant, King, Pend Oreille, Pierce, Skagit, Skamania, Snohomish, Walla Walla, Whitman, and Yakima Counties, and the Upper Skagit Tribe.

PATHS (Promoting Alternative Thinking Strategies) seeks to promote emotional and social competencies and reduce aggression and behavior problems in elementary school-aged children, while simultaneously enhancing the educational process in the classroom. Educators and counselors use it in classroom settings. Although it focuses primarily on the students, information and activities are included for use with parents. Implemented in Thurston County.

Positive Action aims to improve the academic achievement and behavior of children and adolescents. It is intensive, with lessons at each grade level from kindergarten through 12th grade that are reinforced all day, school-wide, at home, and in the community. Components can stand alone, and are useful in a variety of settings beyond the school. Implemented in Spokane County.

Project ALERT is a school-based, social resistance approach that specifically targets cigarettes, alcohol, and marijuana use. Implemented in Adams, Benton/Franklin, Garfield, Jefferson, King, Pacific, Pierce, and Whatcom Counties, and the Puyallup Tribe.

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) provides a full range of substance use prevention and early intervention services. The program places highly trained professionals in schools to work with high-risk youth ages 14-18. Implemented in Kittitas and Klickitat Counties.

Project Towards No Drug Abuse provides detailed information to older teens about the social and health consequences of drug use. The program also provides instruction in active listening, effective communication skills, stress management, tobacco cessation techniques, and self-control. Implemented in Pierce County.

Second Step is a classroom-based social skills program for preschool through junior high students. It aims at reducing aggressive behaviors and increasing children's social-emotional competence. Implemented in Pend Oreille and Spokane Counties.

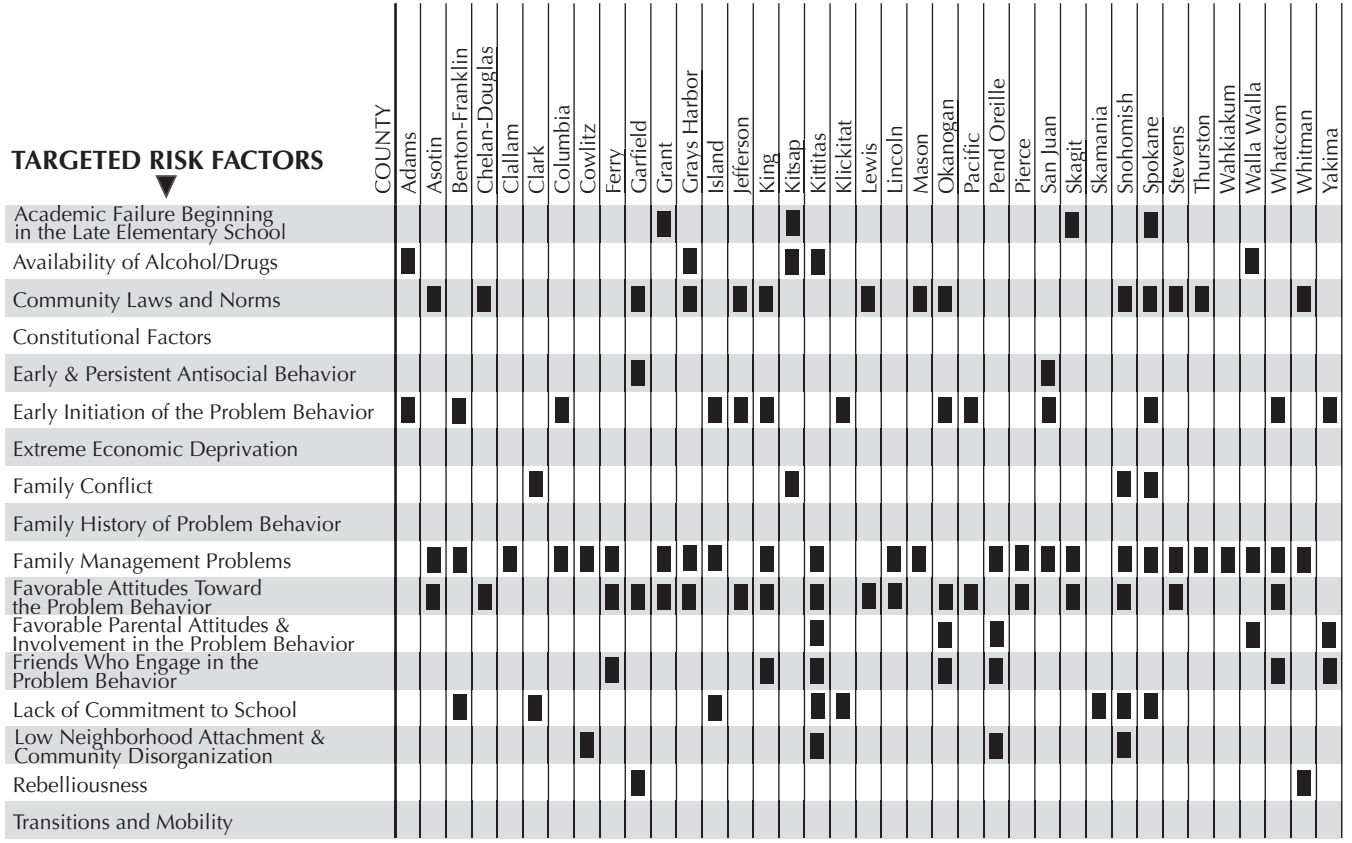
Sembrando Salud is a culturally sensitive anti-tobacco and alcohol use program specifically adapted for migrant Hispanic youth and their families. The program enhances parent-child communication skills as a way of improving and maintaining healthy youth decision-making. It utilizes a school and family curriculum delivered by bilingual/bicultural college students. Implemented in Skagit County.

SMART Leaders is a two-year booster program for youth who have completed "Stay SMART," a component of Boys & Girls Clubs of America's SMART Moves program. It reinforces the substance abuse prevention skills and knowledge of the first program, with sessions on self-concept, coping with stress, and resisting media pressures. Implemented in Jefferson and Whatcom Counties.

Keep A Clear Mind is a parent/child program for families with children in grades 4 through 6. This home-based program uses a correspondence format and consists of lessons on alcohol, tobacco, marijuana, and tools to avoid drugs. The overall goal is to increase parent/child communication, and to develop specific youth beliefs and skills to refuse and avoid "gateway" drug use. Implemented in Pacific, Stevens, and Walla Walla Counties.

County Prioritized Risk Factors

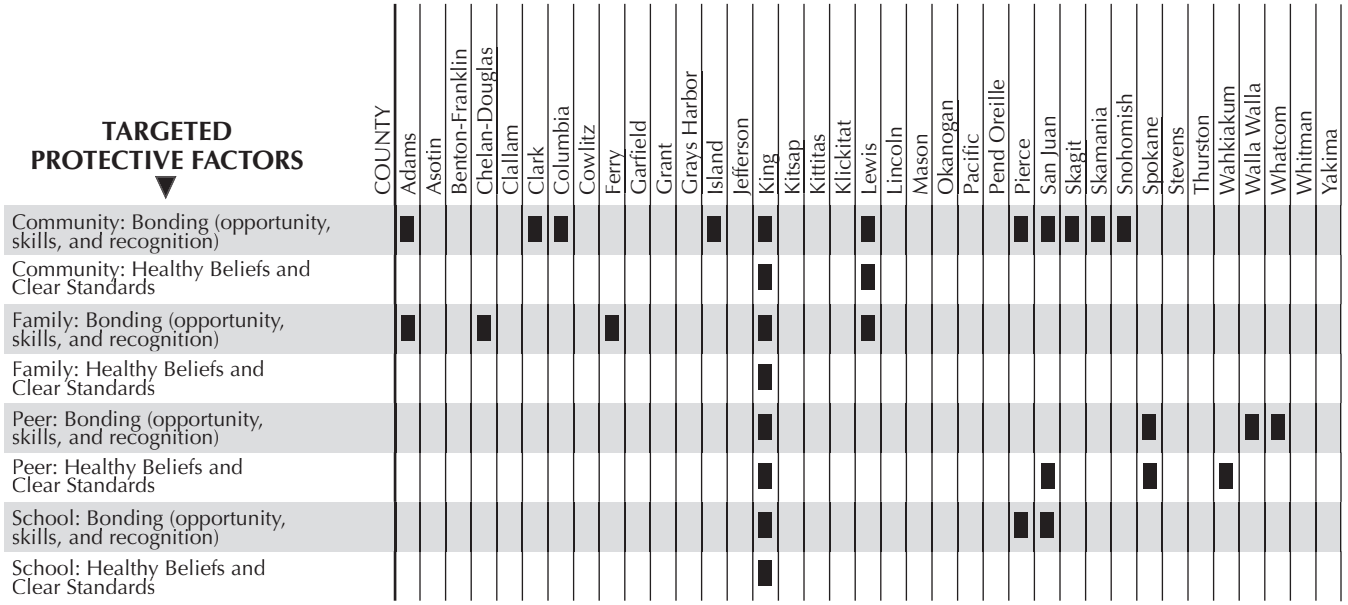
The table below displays a summary of the prioritized risk factors for the 2003-2005 Biennium being addressed by each of the 39 counties in Washington State.



Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.

County Prioritized Protective Factors

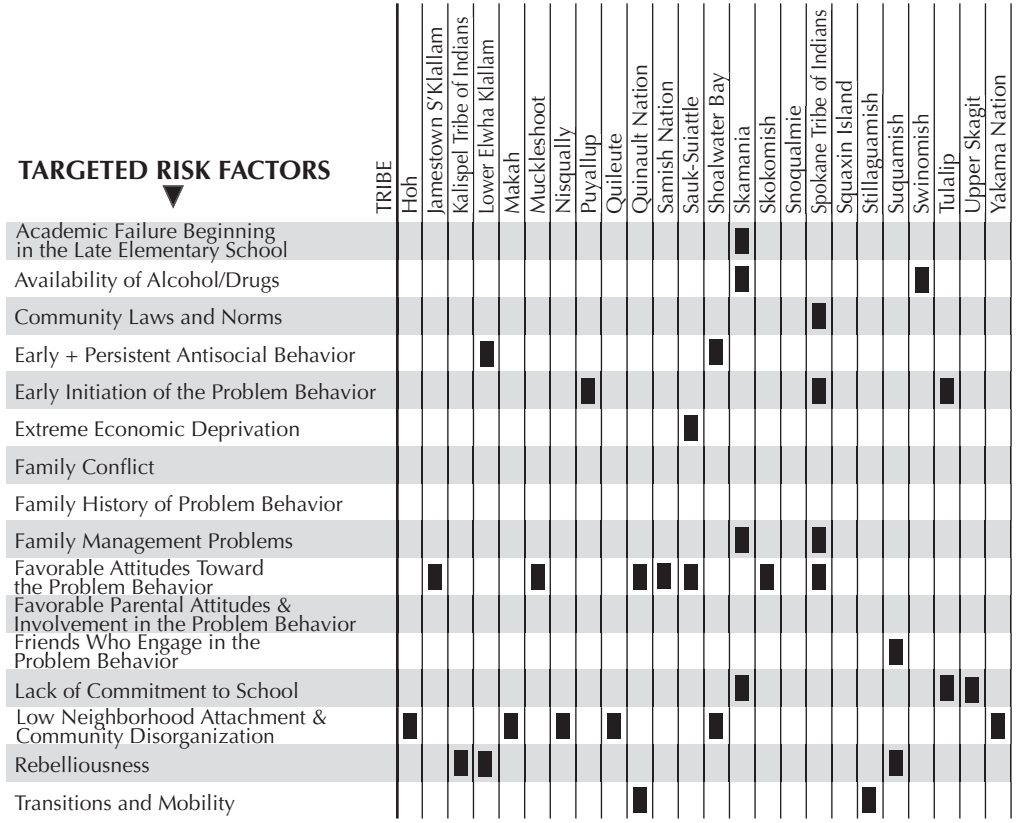
The table below displays a summary of prioritized protective factors for the 2003-2005 Biennium being addressed by each of the 39 counties in Washington State.



Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.

Tribal Prioritized Risk Factors

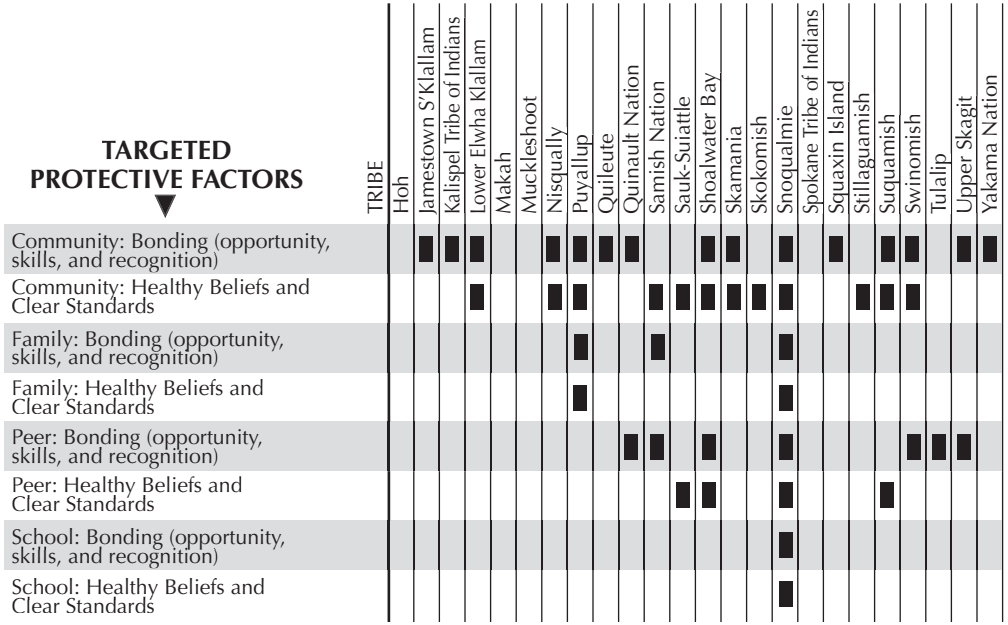
The table below displays a summary of the prioritized risk factors for the 2003-2005 Biennium being addressed by 22 tribes in Washington State that have prevention contracts with the Division of Alcohol and Substance Abuse.



Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.

Tribal Prioritized Protective Factors

The table below displays a summary of the prioritized protective factors for the 2003-2005 Biennium being addressed by 22 tribes in Washington State that have prevention contracts with the Division of Alcohol and Substance Abuse.

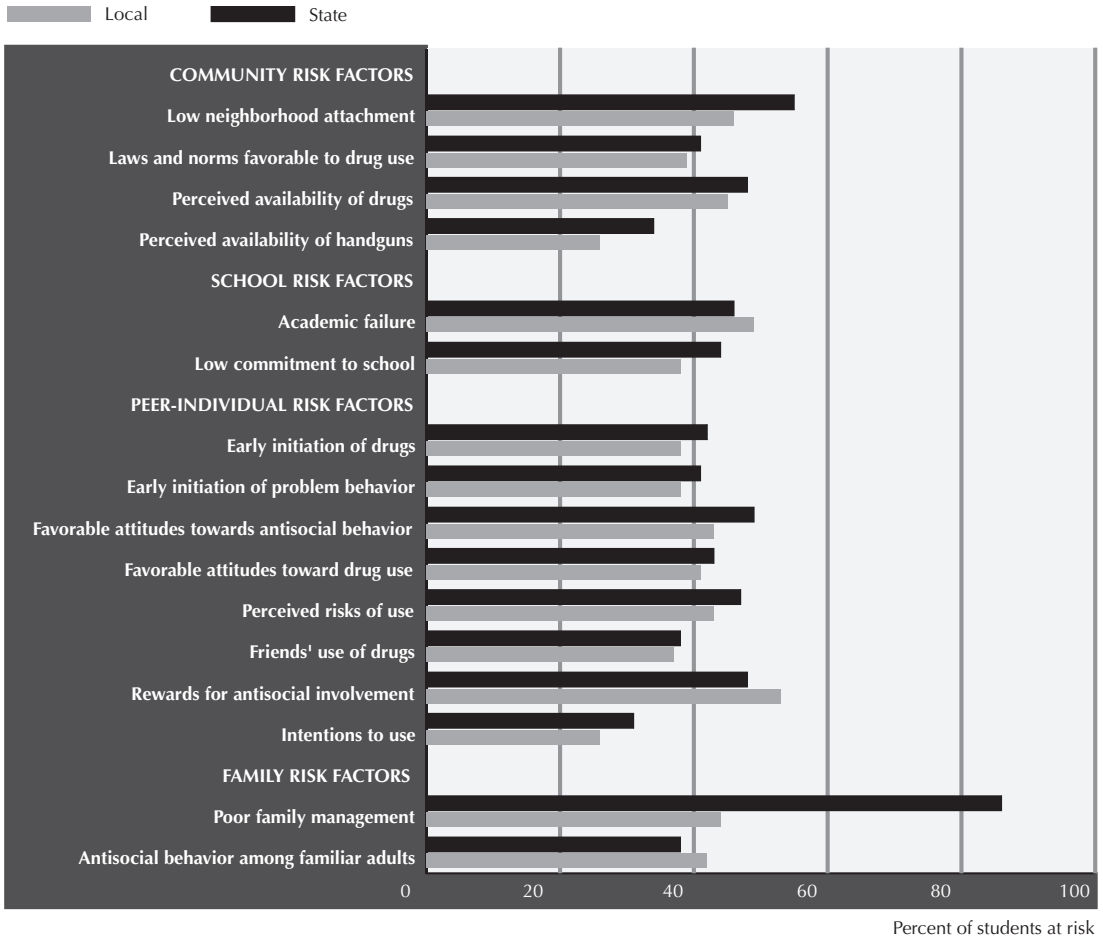


Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.

Using Data to Inform County Prevention Planning

In order to make wise decisions about the use of prevention resources, counties rely on having access to sound data, both about their own communities, and how they compare to demographically similar counties and the state as a whole. One source of such data is the Healthy Youth Survey. Counties are presented with data regarding the percentage of youth at risk or protected in each of the risk/protective factor categories.

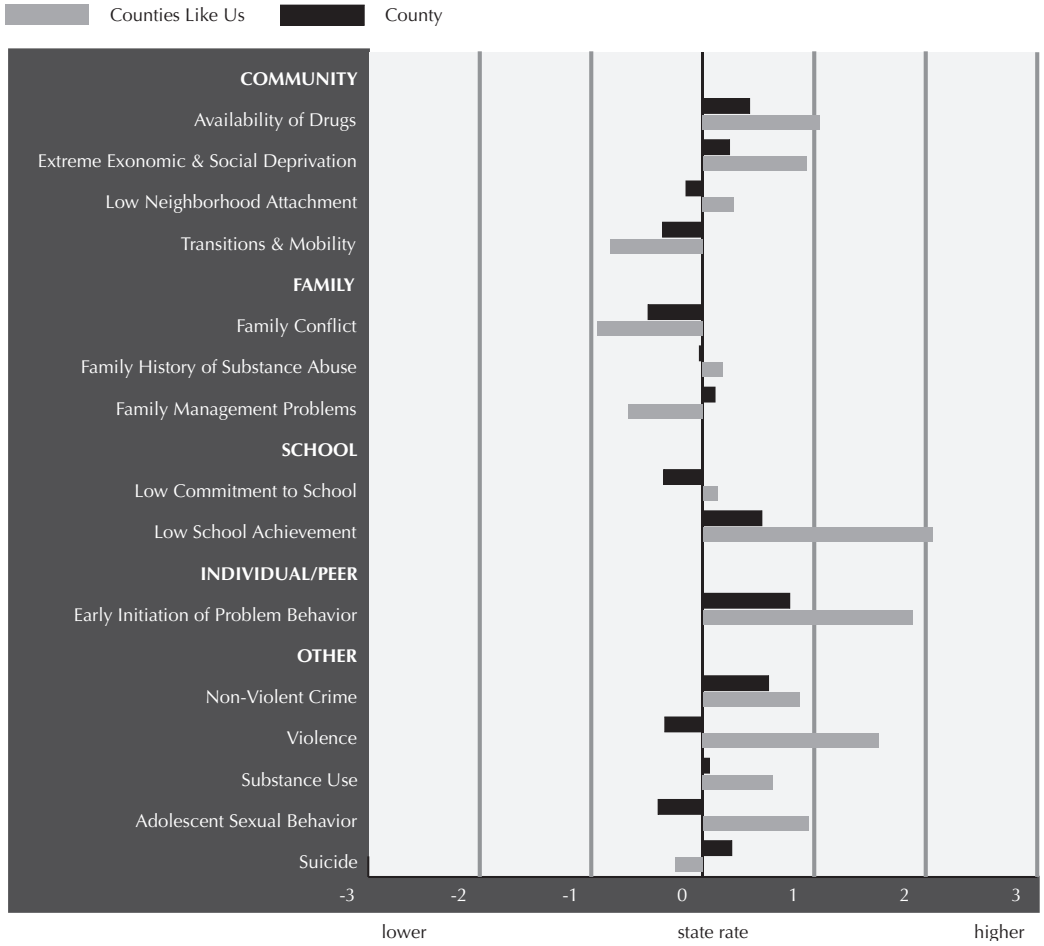
Below is an example of a chart of risk factor results that a county might receive.



Using Data to Inform County Prevention Planning

In order to make wise decisions about the use of prevention resources, counties rely on having access to sound data, both about their own communities, and how they compare to demographically similar counties, and to the state as a whole. Counties are presented with archival data related to risk factors in their communities. Various archival data sources are utilized to derive a summary measure profile

Below is an example of a chart displaying archival summary measure profile data that a county might receive.



Using Prevention Science

Most participants enrolled in prevention programs funded by the Division of Alcohol and Substance Abuse (DASA) receive services proven to be effective in reducing substance use and other problem behaviors. DASA stresses the use of strategies scientifically proven to reduce substance abuse, while at the same time recognizing the importance of local innovation to develop programs for specific populations or emerging problems.

Best Practices

Best practices are those strategies, activities, or approaches that have been shown through substantial research and evaluation to be effective at preventing and/or delaying substance abuse. DASA utilizes best practices listed by the Center for Substance Abuse Prevention, Western Center for the Application of Prevention Technologies. This list includes programs deemed research-based by scientists and researchers at: National Institute of Drug Abuse; Center for Substance Abuse Prevention; National Center for the Advancement of Prevention; Office of Juvenile Justice and Delinquency Prevention; and the federal Centers for Disease Control and Prevention.

Promising Practices

Promising practices are programs and strategies that have some quantitative data indicating positive outcomes in delaying substance abuse over a period of time, but do not have enough research or replication to support generalizable outcomes.

Innovation

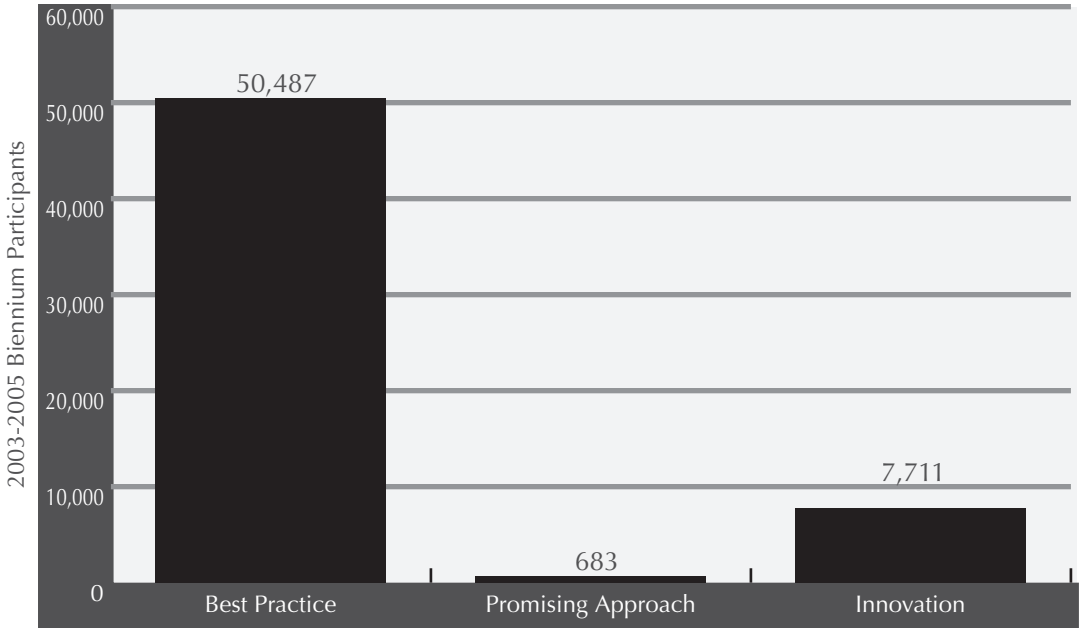
Innovative programs and strategies are developed locally to address a specific need or issue. Development is guided by proven principles of effectiveness. These programs have generally not undergone the rigorous scientific review of a best practice.

Guiding Principles

Guiding principles are recommendations on how to create effective prevention programs. When a community already has a prevention program or strategy in place, the guiding principles can be used to gauge the program's potential effectiveness. They can also be used to design an innovative program/strategy when none of the best practices are appropriate to the community's needs.

DASA requires 50% of county prevention programs to utilize best or promising practices. All DASA-funded prevention programs must adhere to the guiding principles to ensure effective implementation. In the 2003-2005 Biennium, 70% of DASA-funded prevention programs represent best or promising practices, exceeding the 50% requirement.

The Majority of Participants in DASA-Funded Prevention Programs are in Programs Using Best Practices.



Source: Washington State Performance-Based Prevention System.

The Division of Alcohol and Substance Abuse stresses the use of proven strategies to reduce substance abuse, while recognizing the importance of local innovation to develop programs for specific population or emerging problems. Best practices are strategies, activities, or approaches which have been shown scientifically to prevent and/or delay substance abuse. Promising approaches have some quantitative data demonstrating positive outcomes, but not enough research or replication to support generalizable outcomes. Innovative programs or strategies are developed locally to address a specific need or issue.

DASA Prevention Programs Save the State Money

Funds spent on prevention services are a sound investment in reducing burdens to the taxpayer. Research conducted by the Washington State Institute for Public Policy (WSIPP) in 2004 provided a cost-benefit analysis of prevention programs.[1] Prevention programs save money through reduced costs associated with drug addiction, criminal justice, and health care. These cost savings are realized over the life of the participant. By selecting programs with proven research behind them, prevention providers funded by the Division of Alcohol and Substance Abuse save Washington State taxpayers millions of dollars.

Using the results from the WSIPP study, and based on the number of program recipients, the chart below indicates the level of savings achieved as a result of 11 research-based programs implemented in the 2003-2005 Biennium:

Program Name	Net Cost Benefit per Participant[1]	# of DASA Participants[2]	Total Cost Benefit[2]
All Stars	$120	375	$45,000
Guiding Good Choices/Preparing for the Drug Free Years	$6,918	374	$2,587,332
Life Skills Training Program	$717	6,625	$4,750,125
Mentoring: Big Brothers/Big Sisters	$2,822	666	$1,879,452
Parents as Teachers	$800	26	$20,800
Project ALERT	$54	5,729	$309,366
Project Northland	$1,423	398	$566,354
Project SUCCESS (OSPI)	$485	28,522	$13,833,170
Project Towards No Drug Abuse	$274	425	$116,450
SMART leaders	$485	59	$28,615
Strengthening Families Program	$5,805	1,827	$10,605,735

[1]Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth.* Olympia, WA: Washington State Institute for Public Policy, 2004.
[2]Washington State Division of Alcohol and Substance Abuse Performance-Based Prevention System.

Statewide Prevention Services and Programs

The Division of Alcohol and Substance Abuse (DASA) funds statewide services primarily by way of interagency agreements and partnerships with state agencies and non-profit organizations. The following programs are either partially or fully funded by DASA:

School-Based Prevention and Intervention Services Program

The Office of Superintendent of Public Instruction (OSPI) administers a school-based program targeting students at risk for developing alcohol, tobacco, and other drug-related problems. During the 2003-2005 Biennium, more than 300 Prevention/ Intervention Specialists implemented programs in ten Educational Service Districts and three school districts. These services were offered in all the regions of the state and were delivered to over 28,000 kindergarten through twelfth grade students.

Healthy Youth Survey

OSPI administers an adolescent health behavior survey every other year. Substance abuse prevalence and risk/protective factor data are generated from this survey and used by prevention planners and service providers throughout our state. The 2004 Healthy Youth Survey was the eighth time health-related attitudes and behaviors of Washington's public school students have been assessed. More than 185,000 students in elementary, middle, and high schools across the state participated in the survey

Reducing Underage Drinking Initiative (RUaD)

RUaD's goal is to prevent or reduce the consumption of alcohol by minors, especially through increased enforcement of underage drinking laws. The RUaD program has received block grant awards totaling $2,866,000 since 1998 from the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP). The block grants have supported public education efforts, Liquor Control Board enhancements, a RUaD track and/or workshops at the State Prevention Summit, youth leadership activities, and community-based coalitions. In addition to the block grants, DASA is the recipient of three discretionary grants of nearly $1,850,000. These funds support the efforts of five communities as they implement comprehensive approaches to the problem of underage drinking, with an emphasis on increasing law enforcement activity. Washington Traffic Safety Commission and the Washington State Liquor Control Board are primary partners in RUaD. Other collaborators include: local law enforcement, Mothers Against Drunk Driving, the statewide College Coalition for Substance Abuse Prevention, and other state agencies.

Reducing Access to Tobacco Products (Synar Regulation)

The Substance Abuse Prevention and Treatment (SAPT) block grant requires that states focus on reducing youth access to tobacco products through retail outlets. The Synar Regulation requires that states reach and maintain a maximum 20% non-compliance rate as measured through compliance checks. Washington has always been in compliance with the Synar regulation. Washington's Synar success is due to DASA's positive and effective relationship with two other state agencies,

the Department of Health (DOH) and the Liquor Control Board. DOH develops a randomized list of tobacco retailers in the state and then asks local health jurisdictions to implement youth access compliance checks. Local health jurisdictions are responsible for implementing the Synar compliance checks assigned to them through the statewide sampling. They report the results of the checks back to DOH. In 2004, the non-compliance rate was 10.1%.

College Coalition for Substance Abuse Prevention

The University of Washington facilitates the College Coalition for Substance Abuse Prevention. Coalition members administer campus-based prevention services targeting students and university communities. The College Coalition was established to provide the development, implementation, and continuation of substance abuse prevention programming at all college and university campuses in Washington State. The coalition meets six times during the academic year on different campuses throughout the state. During the 2003-2005 Biennium, the Coalition sponsored a survey of college and university student alcohol and other drug use.

Children's Transition Initiative (CTI)

DASA established the Children's Transition Initiative (CTI) to encourage prevention providers to address the risk and protective factors in children transitioning from grade school to middle school. CTI requires enrollment of children and their families for a minimum of 10 months, and the utilization of research-based prevention strategies. CTI counties include Benton, Columbia, Ferry, Franklin, Grant, Island, Lincoln, Spokane, and Whatcom.

Alcohol/Drug Clearinghouse

DASA funds the Alcohol/Drug Clearinghouse to provide a wide variety of timely resource materials and information on substance abuse. Materials and information are accessible to Washington State residents, including non-English-speaking individuals and persons with disabilities. The Clearinghouse maintains a statewide toll-free phone number for requesting resources, including a system for receiving requests by telephone from the hearing-impaired community, a website for requesting materials, and a video lending library. Requests for information or materials are usually processed within 24 hours. The Clearinghouse also maintains an electronic newsletter to communicate federal, state, and local prevention news and activities/campaigns to individuals and organizations in Washington State. During the 2003-2005 Biennium, the Clearinghouse distributed over 900,000 resource items, and made resources available to over 200 community and school-based events.

Exemplary Substance Abuse Prevention Awards

The Washington State Exemplary Substance Abuse Prevention Awards Program recognizes outstanding substance abuse prevention programs, including individuals working in the prevention field, and media organizations that support prevention efforts. A review committee evaluates the nominations and approves those meeting the selection criteria. Members of the committee also nominate and select additional awardees for their special contributions to the field. The state awards process is designed to coordinate with the existing national awards process, with the goal of identifying Washington State Exemplary Programs that could be encouraged to apply at the national level. The awards process is conducted in cooperation with the Governor's Prevention Advisory Committee, the Lieutenant Governor's Office, the Citizens Advisory Council on Alcoholism and Drug Addiction, and the Washington Interagency Network.

Community Prevention Capacity Building

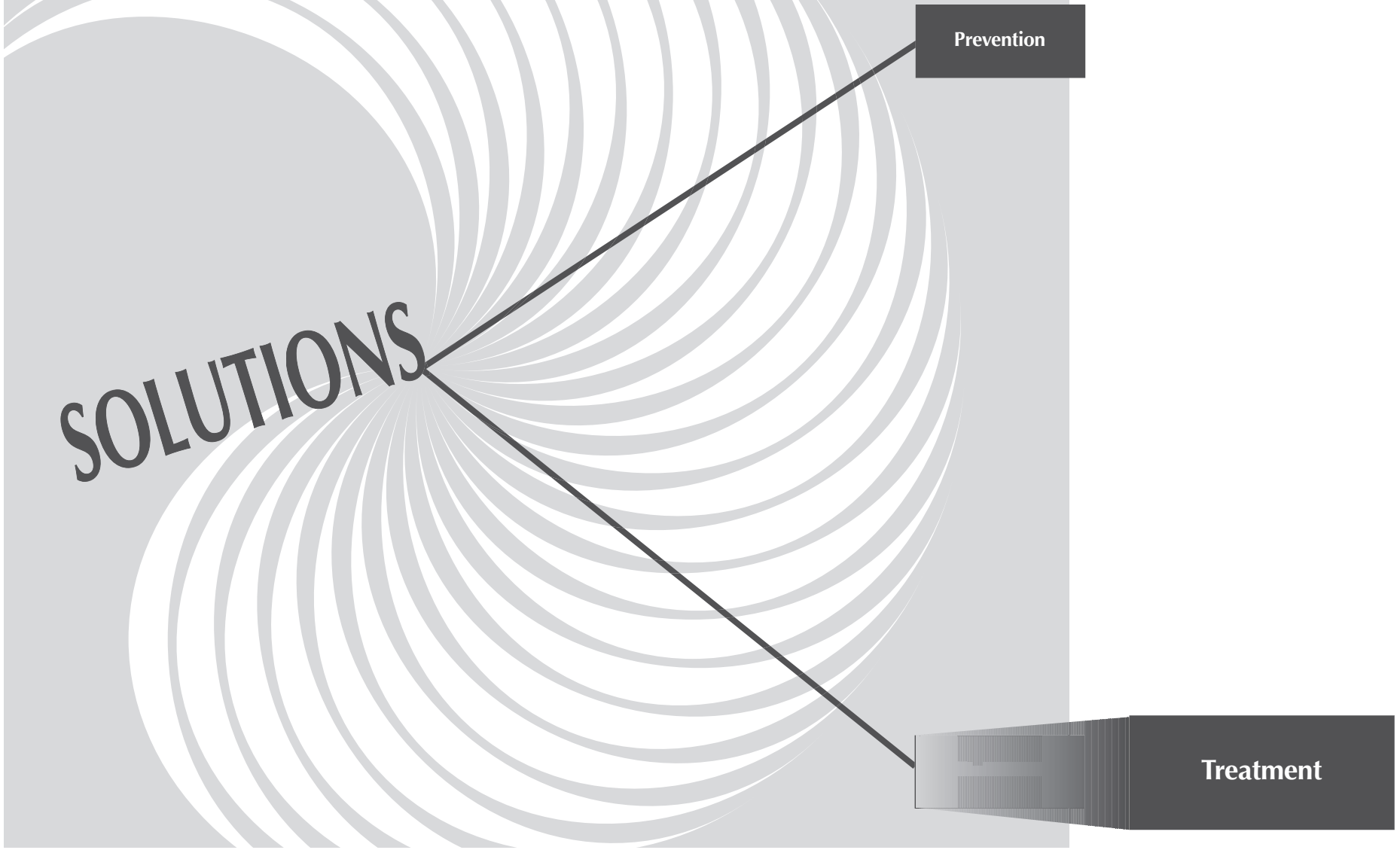
Until the start of the 2003-2005 Biennium, the Community Prevention Training System provided financial support to counties and tribes for capacity building. Now each county has a set amount of funding specifically earmarked for training. It may choose to improve its own abilities to plan and develop programming, or support community members whose participation in training would fill an identified need.

Communication and Media Program

DASA's Communication and Media Program provides materials and technical assistance to communities in Washington State to increase public awareness about the prevention and treatment of alcohol and other drug misuse and dependency. In addition, DASA manages and supports Partnership for a Drug Free Washington (PDFW), a statewide, ongoing media campaign allied with the Partnership for a Drug-Free America. Support for PDFW includes 30 media and corporate partners statewide who have contributed over $2 million in airtime and print advertising.

Through partnerships with corporations, state and community agencies, and advertising and news media, DASA educates the public about the health, social and economic impacts of drug misuse and dependency; alcohol and other drug prevalence and trends; risk and protective factors; media literacy; effective ways to prevent and reduce misuse; and how to access prevention and treatment resources. Messages and campaigns are tailored for professionals, educators, parents, teens, youth, and older adults. Materials are available in English, Spanish, Russian, and Asian languages.

Solutions: Substance Abuse Prevention & Treatment



Introduction

Individuals are eligible for DASA-funded services if they are low-income (generally below 200% of the Federal Poverty Level) or indigent, and are assessed as chemically dependent. For persons applying for treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), eligibility is further restricted to those who are unemployable as a result of their alcohol or other drug addiction. In the 2005-2007 Biennium, treatment services are expanded to include those who have primary Medicaid eligibility (those receiving General Assistance-Unemployable, General Assistance-Expedited, Supplemental Security Income, and Temporary Assistance to Needy Families). Treatment services are designed to maintain a cost-effective, quality continuum of care for rehabilitating alcoholics and drug addicts.

Contracted treatment and support services include:

- Diagnostic evaluation
- Alcohol/Drug detoxification
- Outpatient treatment
- Opiate substitution (methadone) treatment
- Intensive inpatient treatment
- Recovery house
- Long-term residential treatment
- Involuntary treatment/civil commitment for individuals with alcohol/drug addiction
- Youth residential treatment
- Youth outpatient treatment
- Residential treatment for pregnant and parenting women (with therapeutic childcare)
- Outpatient treatment for pregnant and parenting women (with childcare)
- Treatment for co-occurring disorders
- Tribal treatment programs
- Monolingual programs for non-English speakers
- Treatment program for the deaf/hard of hearing
- Urine screening
- Brief interventions and referral from emergency departments
- Support services for those accessing treatment and recovery services
- Alcohol and Drug 24-Hour Help Line

Specialized contracted support services for eligible individuals include:

- Child care
- Translation services (including interpreters for persons who are deaf or hard of hearing)
- Transportation assistance
- Integrated crisis response/secure detoxification services
- Case management
- Youth outreach
- Cooperative housing (Oxford House) and other transitional housing support

State and federal funding requirements give priority for treatment and intervention services to the following:

- Pregnant and postpartum women and families with children
- Families receiving Temporary Assistance for Needy Families (TANF)
- Child Protective Services referrals
- Youth
- Injection drug users (IDUs)
- People with HIV/AIDS

DASA Treatment Philosophy for Alcohol, Tobacco, and Other Drug Addiction

DASA's program of substance abuse services is based on knowledge gained from medical research that alcoholism and addiction to other drugs is a progressive disease. Research and evaluation studies cited throughout this report indicate that long periods of sobriety, abstinence, and/or reduced drug use result from effective intervention and treatment. Research also demonstrates that treatment results in a marked reduction in negative consequences for the addicts, their families, friends, and society at large, as measured by domestic violence, disrupted families, employment histories, and public costs for law enforcement and the courts, welfare dependence, medical and hospital costs, and admissions to psychiatric hospitals.[1] As alcoholism and addiction are chronic, relapsing disorders, continued treatment and support services may be required after any initial course of treatment.

Alcohol, tobacco, or other drug addiction is an individual, family, worksite, and community affliction. These addictions negatively impact all sectors of society regardless of age, education, race/ethnicity, gender, occupation, or socio-economic status. Therefore, it is critical that all citizens – especially teachers, employers, parents, and youth – understand the illness is treatable and the channels for getting a person into private or public treatment agencies. DASA's philosophy recognizes the importance of ensuring all treatment agencies meet established standards for providing services. Treatment must be tailored to the specific needs of each individual, and a continuum of treatment services is essential for matching clients with the optimal types and sequences of treatments. It is also important that specialized treatment services be available for populations with special needs and circumstances, such as adolescents, pregnant and parenting women (and their children), members of minority populations, and those with disabilities.

DASA recognizes that substance abuse treatment cannot occur in isolation from law enforcement and public safety, educational institutions, and social, health, and economic services. It is essential that substance abuse treatment have linkages with all segments of society that are important to recovery and rehabilitation.

A key aspect of DASA's philosophy is recognizing the generational loop of addiction. It is important to break the generational cycle of addiction by promoting alcohol, tobacco, and other drug prevention programs, enrolling children of addicts in appropriate prevention activities, and providing early intervention services when needed.

[1]See, for example: Wickizer, T., and Longhi, D., *Economic Benefits and Costs Associated with Substance Abuse Treatment Provided to Indigent Clients through the Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA).* Olympia, WA: Washington State Department of Social and Health Service, Division of Alcohol and Substance Abuse, 1997. See also: Schrager, L. Joyce, J., and Cawthon, L. *Substance Abuse, Treatment, and Birth Outcomes for Pregnant and Postpartum Women in Washington State.* Olympia, WA: Washington State Department of Social and Health Services, Planning, Research & Development and Office of Research & Data Analysis, 1995.

Substance Use and Current Need for Treatment

Based on the *2003 Washington State Needs Assessment Survey* conducted by the Department of Social and Health Services' Research and Data Analysis Division, 10.9% of the Washington State adult population (age 18 and older) living in households were estimated to be in need of substance abuse treatment in 2003.[1] Treatment need for adolescents (ages 12 to 17) living in households is estimated at 8.7%. (The definition of need for treatment is provided on the following page.)

Alcohol is by far the most used substance in Washington State, and the one for which there is the highest rate of treatment need.

Use rates among adults living in households for individual substances were as follows:

	Lifetime Use	Past 12-Month Use	Past 30-Day Use
Alcohol	88.0%	72.9%	57.9%
Any Illicit Drug	45.2%	9.6%	5.6%
Marijuana	42.2%	7.4%	4.3%
Stimulants*	14.5%	0.5%	0.1%
Cocaine	15.8%	1.1%	0.9%
Opiates**	8.7%	2.0%	0.9%
Heroin	1.7%	0.1%	0.0%

** Includes amphetamine, methamphetamine, and other stimulants.*
*** Other than heroin.*

[1] *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

Current Need for Treatment Among Population Subgroups in Washington State

Based on data from the *2003 Washington State Needs Assessment Household Survey* conducted by the Department of Social and Health Services' Research and Data Analysis Division, the current estimated need for treatment varies widely across population subgroups:

- Compared with the overall treatment need rate of 10.9% of adults living in households, some subgroups have lower rates of treatment need. These include: those ages 45-64 (7.8%) and 65+ (1.8%); females (7.3%); African-Americans (10.4%) and Asians (4.9%); those who are married (5.9%); and college graduates (8.1%).
- Other subgroups have higher estimated needs for treatment. These include: (those ages 18-24 (22.6%) and 25-44 (13.%); males (14.7%); American Indians (15.8%) and multi-race individuals (16.2%); and those never married (21.0%).

Need for chemical dependency treatment is associated with income. Adults living in households with incomes above 200% of the Federal Poverty Level (FPL) have lower rates of treatment need (10.0%) than do adults living in households with incomes below 200% FPL (13.6%).

Those classified as in need of chemical dependency treatment in the past year met one or more of the following conditions.

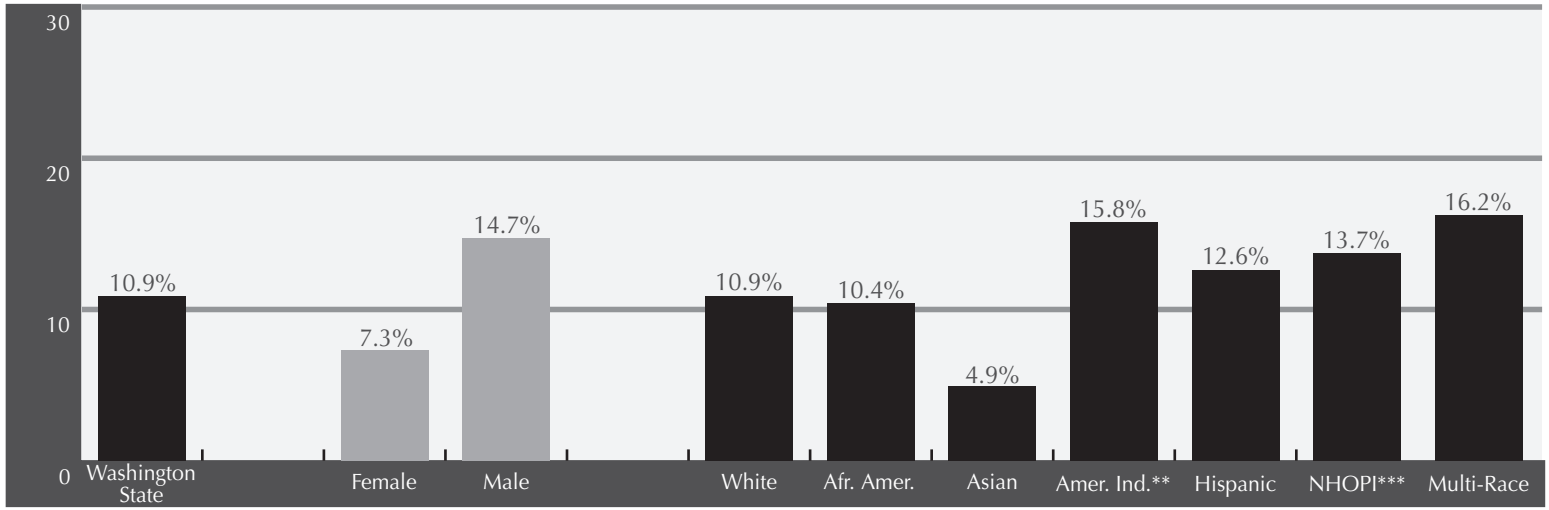
1. Reported life DSM-IV* alcohol or drug abuse or dependence symptoms, reported at least one symptom in the past 12 months, and used alcohol or drugs in the past 12 months.
2. Received professional alcohol or drug treatment (excluding detoxification) during the past 12 months.
3. Reported having a problem with alcohol or drugs and were using alcohol or drugs regularly during the past 12 months. Regular alcohol use is defined as having three or more drinks at least one day per week. Regular drug use is defined as using marijuana 34 or more times in the past 12 months or as using other illicit drugs eight or more times in the past 12 months.
4. Reported heavy use of drugs or alcohol in the past 12 months. Heavy alcohol use is defined as four or more drinks per drinking day, three or more days per week during the past 12 months. Heavy drug use is defined as using any illicit substance 34 or more times during the past 12 months.

**DSM-IV is the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association in 1994. It contains diagnostic criteria for the most common mental disorders, and includes findings on description, diagnosis, treatment, and research.*

More than One Out of Ten Washington State Adult Residents is in Need of Chemical Dependency Treatment.*

Current Need for Treatment

Percent of Adults in Households

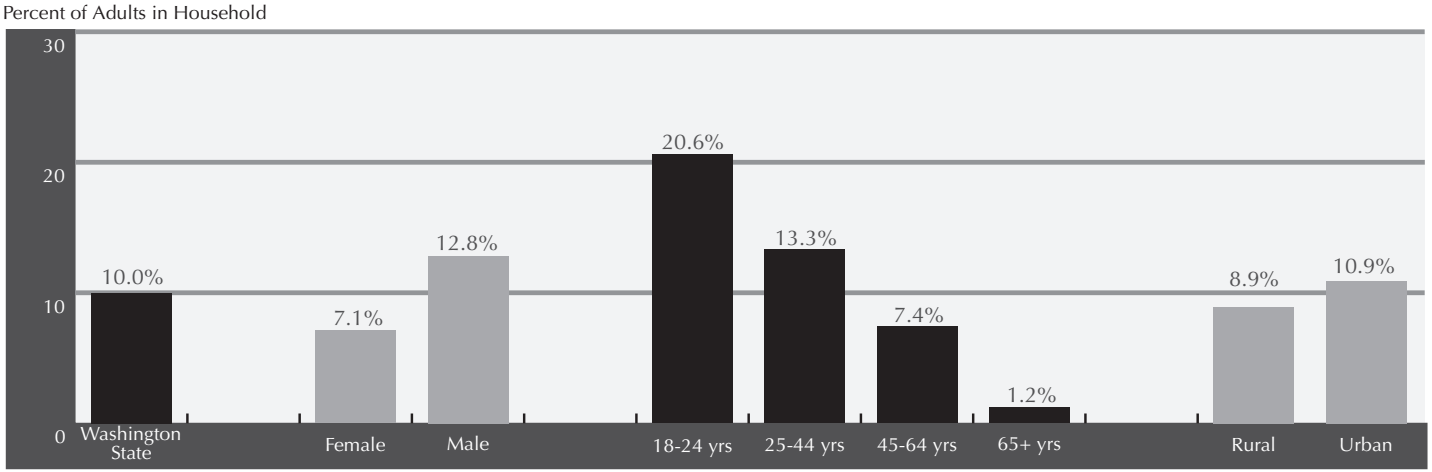


Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

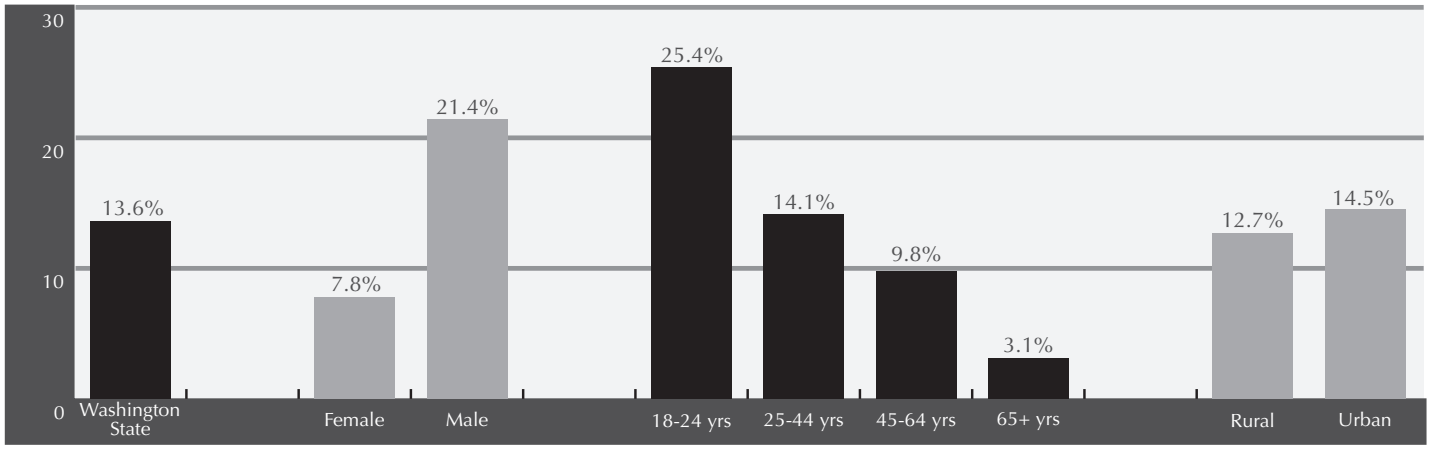
** For definition of Current Need for Treatment, see page 176.*
** American Indian Includes Alaskan Natives.
*** Native Hawaiian or Pacific Islander.

Younger Adults (Ages 18-24), Males, and Urban Residents Have Higher Rates of Need for Chemical Dependency Treatment.*

Current Need for Treatment Among Adults Above 200% of Federal Poverty Level



Current Need for Treatment Among Adults at or Below 200% of Federal Poverty Level



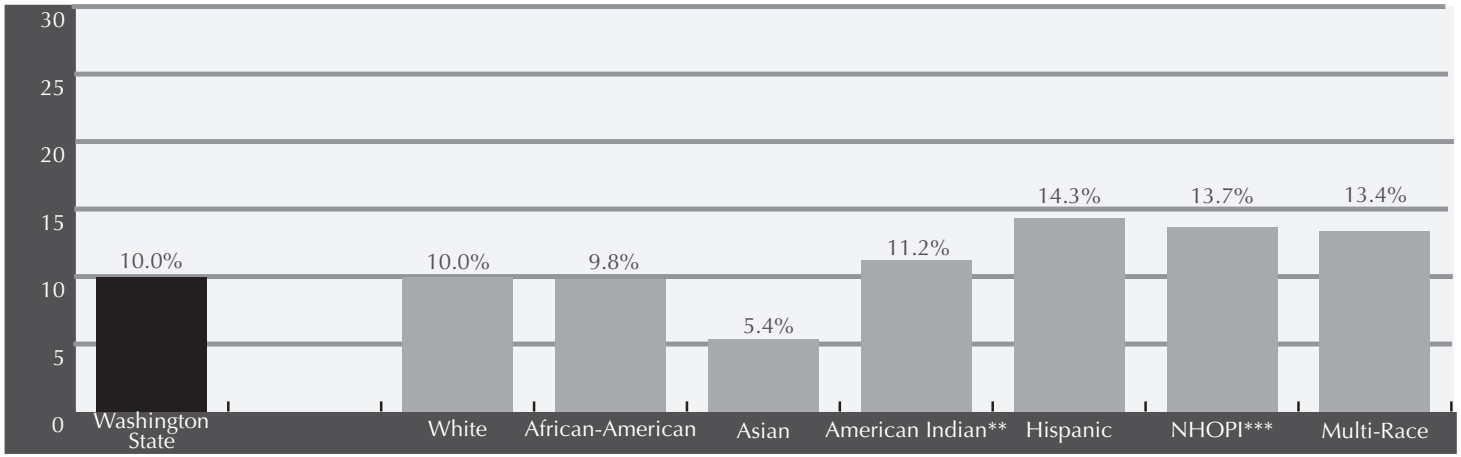
Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

* For definition of Current Need for Treatment, see page 176.

White, American Indian, and Multi-Race Washington State Adult Residents Have Higher Rates of Chemical Dependency Treatment Need.*

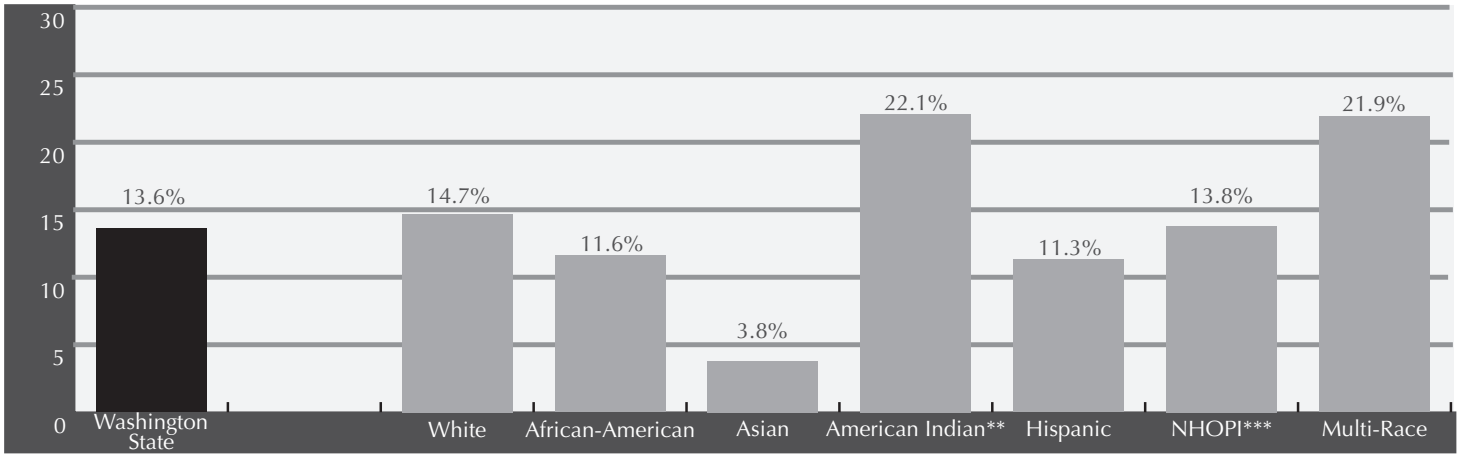
Current Need for Treatment for Adults Above 200% of the Federal Poverty Level

Percent of Adults in Households



Current Need for Treatment for Adults at or Below 200% of the Federal Poverty Level

Percent of Adults in Households



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

**For definition of Current Neeed for Treatment, see page 176.*
**American Indian includes Alaskan Natives.
***Native Hawaiian or Pacific Islander.

Computing the DASA Treatment Gap

The Treatment Gap rate is a measure over a given period of time of those who qualify – both clinically and financially – for Division of Alcohol and Substance Abuse (DASA)-funded treatment services but who, because of the limits of available funding, do not receive it. To compute the treatment gap, an estimate is established of all those at or below 200% of the Federal Poverty Level (FPL) and in need of treatment. Those with private insurance, access to military health services, or who are enrolled in the subsidized portion of the Washington Basic Health Plan (BHP) are subtracted from this number, as these individuals would be expected to access chemical dependency treatment services without use of DASA funds.

The following equation is then used to compute the DASA Treatment Gap:

$$\textbf{DASA Treatment Gap Rate} = \frac{\text{\# of county residents qualifying for and requiring DASA-funded treatment minus those receiving it}}{\text{\# of county residents qualifying for and requiring DASA-funded treatment}} \times 100$$

The statewide treatment gap is computed by aggregating the county numbers and using the same formula. Counts of persons receiving DASA-funded treatment are drawn from DASA's TARGET system. These counts represent cases that were open in SFY 2003. Individuals must have received at least one residential or outpatient service during this period. Persons receiving more than one treatment service are only counted once.

Only those living in households are included. Those residing in institutions or group care settings are excluded from both the numerator and denominator. Results by county are displayed on page 182.

For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone number are found on the back cover.

The Treatment Gap

SFY 2003 Treatment Gap Rates in Washington State for Publicly Funded Chemical Dependency Services

Target Population	Needing & Eligible for DASA-Funded Treatment	Received Treatment with DASA-Funded Support	Number of Eligible Individuals Unserved	Treatment Gap Rate (Unserved Need)
Adults w/children < 18	34,389	10,554	23,835	69.3%
Adults w/o children under 18	61,807	14,785	47,022	76.1%
ALL ADULTS 18 AND OLDER	**96,196**	**25,339**	**70,857**	**73.7%**
ADOLESCENTS (AGES 12 - 17)	**18,930**	**5,875**	**13,055**	**69.0%**
TOTAL	**115,126**	**31,214**	**83,912**	**72.9%**

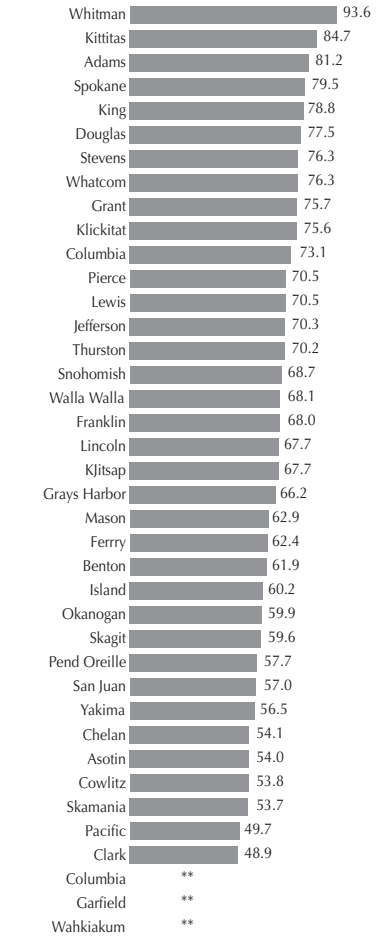
Estimates exclude detox, transitional housing, and Department of Corrections. Also excluded are adults who have private, Washington Basic Health Plan, or military health insurance. An addition adjustment was made to include individuals estimated to be eligible for DASA-funded treatment at some time during the 12-month period.

For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone are found on the back cover.

Statewide, in SFY 2003, 76.3% of Adults in Household Who Qualified for and were in Need of DASA-Funded Chemical Dependency Treatment Did Not Receive It.*

County	Percent of Adults <200% FPL & in need of Treatment	Number of Adults <200% FPL Receiving Treatment	Number of Adults Not Receiving Treatment	Penetration Rate	Treatment Gap
Adams	12.0%	67	289	18.8%	81.2%
Asotin	14.4%	178	209	46.0%	54.0%
Benton	13.7%	687	1,114	38.1%	61.9%
Chelan	12.6%	461	544	45.9%	54.1%
Clallam	13.4%	634	606	51.1%	48.9%
Clark	14.1%	1,173	3,180	26.9%	73.1%
Columbia	12.2%	56	**	**	**
Cowlitz	14.0%	824	960	46.2%	53.8%
Douglas	12.3%	128	441	22.5%	77.5%
Ferry	16.7%	102	169	37.6%	62.4%
Franklin	11.7%	351	746	32.0%	68.0%
Garfield	12.9%	20	**	**	**
Grant	13.0%	462	1,443	24.3%	75.7%
Grays Harbor	13.3%	469	917	33.8%	66.2%
Island	13.8%	275	415	39.8%	60.2%
Jefferson	12.8%	154	365	29.7%	70.3%
King	13.6%	5,013	18,591	21.2%	78.8%
Kitsap	14.2%	1,071	2,248	32.3%	67.7%
Kittitas	20.4%	209	1,154	15.3%	84.7%
Klickitat	13.9%	110	340	24.4%	75.6%
Lewis	13.5%	443	1,058	29.5%	70.5%
Lincoln	12.3%	47	98	32.3%	67.7%
Mason	14.2%	330	561	37.1%	62.9%
Okanogan	13.8%	467	698	40.1%	59.9%
Pacific	12.0%	225	223	50.3%	49.7%
Pend Oreille	13.4%	115	157	42.3%	57.7%
Pierce	13.7%	3,123	7,470	29.5%	70.5%
San Juan	13.2%	112	149	43.0%	57.0%
Skagit	12.8%	686	1,011	40.4%	59.6%
Skamania	13.8%	79	92	46.2%	53.8%
Snohomish	13.1%	2,339	5,128	31.3%	68.7%
Spokane	16.0%	1,848	7,164	20.5%	79.5%
Stevens	14.2%	218	718	23.3%	76.7%
Thurston	15.5%	912	2,143	29.8%	70.2%
Wahkiakum	15.6%	39	**	**	**
Walla Walla	15.0%	360	769	31.9%	68.1%
Whatcom	18.4%	1,011	3,255	23.7%	76.3%
Whitman	22.9%	110	1,620	6.4%	93.6%
Yakima	12.1%	2,060	2,678	43.5%	56.5%

Treatment Gap Rates



*Estimates exclude adults who have private, Washington Basic Health Plan, or military health insurance. An addition adjustment was made to include individuals estimated to be eligible for DASA-funded treatment at some time during the 12-month period.

**Treatment penetrations rates suppressed for counties with 60 or fewer adults estimated to need and be eligible for DASA-funded treatment.

For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone are found on the back cover.

Estimates of Substance Abuse and Treatment Need in Washington State, 2003

	Adult Household Residents		Adults in Households At or Below 200% of Federal Poverty Level	
	# of Residents	% of Residents	# of Residents	% of Residents
NEED FOR TREATMENT				
Current Need for Substance Treatment	478,846	10.9%	144,278	13.6%
ALCOHOL OR DRUG DISORDER				
Lifetime Alcohol or Drug Use Disorder	901,068	20.5%	217,602	20.5%
Past 12-Month Alcohol or Drug Use Disorder	342,325	7.8%	98,909	9.3%
ALCOHOL USE				
Lifetime Use of Alcohol	3,870,608	88.0%	817,738	77.2%
Past 12-Month Use of Alcohol	3,208,952	72.9%	618,413	58.4%
Past 30-Day Use of Alcohol	2,547,638	57.9%	440,971	41.6%
ALCOHOL DISORDER				
Lifetime Alcohol Use Disorder	751,246	17.1%	167,513	15.8%
Past 12-Month Alcohol Use Disorder	308,748	7.0%	81,442	7.7%
USE OF ANY DRUG				
Lifetime Use of Any Illicit Drug	1,988,655	45.2%	442,567	41.8%
Past 12-Month	424,263	9.6%	134,929	12.7%
Past 30-Day Use of Any Illicit Drug	247,818	5.6%	79,743	7.5%
MARIJUANA USE				
Lifetime Use of Marijuana	1,855,293	42.2%	406,257	38.4%
Past 12-Month Use of Marijuana	325,443	7.4%	101,464	9.6%
Past 30-Day Use of Marijuana	190,820	4.3%	62,007	5.9%
STIMULANT USE				
Lifetime Use of Stimulants	636,177	14.5%	154,148	14.6%
Past 12-Month Use of Stimulants	22,359	0.5%	12,497	1.2%
Past 30-Day Use of Stimulants	6,061	0.1%	4,725	0.4%
COCAINE USE				
Lifetime Use of Cocaine	693,276	15.8%	167,526	15.8%
Past 12-Month Use of Cocaine	48,987	1.1%	21,261	2.0%
Past 30-Day Use of Cocaine	15,508	0.4%	6,993	0.7%
DRUG DISORDER				
Lifetime Drug Use Disorder	317,122	7.2%	102,325	9.7%
Past 12-Month Drug Use Disorder	79,552	1.8%	37,107	3.5%

Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

Estimates of Current Need for Substance Abuse Treatment in Washington State, 2003

	Adult Household Residents			Adults In Household at or below 200% of Federal Poverty Level		
GROUP	Population	# Needing Treatment	% Needing Treatment	Population	# Needing Treatment	% Needing Treatment
Total	4,400,316	478,846	10.9%	1,058,918	144,278	13.6%
AGE						
18-24	510,517	115,446	22.6%	217,524	55,193	25.4%
25-44	1,751,416	235,960	13.5%	439,524	62,114	14.1%
45-64	1,497,819	116,099	7.8%	216,555	21,302	9.8%
65+	640,564	11,342	1.8%	185,315	5,670	3.1%
SEX						
Male	2,146,952	315,469	14.7%	461,923	98,974	21.4%
Female	2,253,364	163,376	7.3%	596,994	45,304	7.6%
RACE/ETHNICITY						
White-NH	3,592,265	392,882	10.9%	732,678	106,054	14.7%
Black-NH	121,115	12,637	10.4%	40,917	4,757	11.6%
Asian	246,424	12,000	4.9%	81,624	3,116	3.8%
Amer. Indian*	56,055	8,873	15.8%	23,898	5,273	22.1%
NHOPI**	12,254	1,683	13.7%	4,610	636	13.8%
Multi-Race	104,862	17,010	16.2%	34,716	7,590	21,9%
Hispanic	267,343	33,761	12.6%	149,475	16,853	11.3%
MARITAL						
Married	2,620,202	208,445	8.0%	455,415	44,929	9.9%
Div/Sep	649,928	72,709	11.2%	211,992	23,010	10.9%
Widowed	257,456	10,160	3.9%	104,004	3,765	3.6%
Never Mar	872,730	187,531	21.5%	287,507	72,575	25.2%
EDUCATION						
Not HS Grad	354,637	40,723	11.5%	211,817	23,040	10.9%
HS Graduate	4,045,679	438,123	10.8%	847,101	121,238	14.3%
POVERTY						
Below 200%	1,058,918	144,278	13.6%	1,058,918	144,278	13.6%
Above 200%	3,341,399	334,567	10.0%	-	-	-

*American Indian includes Alaskan Native.

**Native Hawaiian or Pacific Islander

Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.